

**New Jersey State Employment and Training Commission
Health Care Workforce Council
NJHA Boardroom, Princeton
February 18, 2011**

Minutes

I. Welcome & Chairman's Remarks – Robert P. Wise, Chair, Health Care Workforce Council

The meeting was called to order at 8:05 am by Chairman Robert Wise, and he welcomed all members to the meeting. He thanked members for their contributions to the data requested in preparation for this meeting. Chairman Wise indicated that the work for this meeting will be for members to share perspectives – the data gathered from the occupational priorities survey will be used to “test” those perspectives.

II. Discussion and Consensus of Council Members on Strategic Models/Vision for Future – Robert P. Wise

Chairman Wise discussed the Reinhardt Commission report, which examines issues including the availability of hospital beds, the regionalization of health care, and the categorization of community, trauma and specialty centers of care. It provides a vision for the future health care system in New Jersey, but the report has not yet been effectively used as a template for discussions around change to the health care system. Again, the perspectives of the Council members can be used to challenge or validate the Reinhardt Commission findings. Since the report was published, national health care reform has happened. The reforms being made now may change, or even accelerate, some assumptions of the Reinhardt report. New federal incentives, or disincentives, are in place and also may change how the report's findings can be moved forward.

In ranking priorities, the council members have shared their perspectives about current and future demand for a large array of health care professions. Today, each member is asked to provide input and discussion on the occupations and workforce pipelines that the council should focus on. Chairman Wise initiated the roundtable discussion, asking each member to discuss their role, their organization's efforts, and their thoughts about the necessary focus for the health care system in New Jersey.

Bob Schwaneberg, Policy Advisor to the Governor for Health Care, indicated that the Governor's office will look to this Council for expert advice on future health care needs, the barriers that exist to meeting those needs and how to develop a plan to meet future needs in New Jersey. He noted that the Affordable Care Act has created a “chicken and egg” issue when trying to formulate assumptions about where health care is going. The state has a work group on the Affordable Care Act, which is exploring how to setup a health insurance exchange. The state has received a grant and is working with the Rutgers Center for State Health Policy (CSHP). As part of this effort, the CSHP will

create projections of the demographics of those who will be eligible for Medicaid in 2014, including who will still be uninsured at that point. These projections will help inform how health care can be delivered to this population, and can be shared with the Workforce Council. Also, the state's Medicaid Long Term Care Advisory Council is examining the delivery of long-term care, and how to balance delivery between nursing homes and in-home settings. He noted a recent California study which gave staggering projections for the future needs of Alzheimer's patients, and the associated costs of caring for these patients. However, Mr. Schwaneberg indicated that the same types of workers might be needed, regardless of whether care is delivered in-home or at a nursing facility. The Governor's goals for health care include an emphasis on early detection and preventative care. Guidance from the federal government is still needed to determine how accountable care organizations will be developed. The model presented by Dr. Jeff Brenner in Camden is being examined by the Governor's office as well, with particular focus on how it might be replicated and expanded to serve a larger population.

Mr. Schwaneberg also discussed the NJ Protect health insurance program for high-risk pool customers, which is federally subsidized but run by the state. There are currently just 347 people enrolled statewide, not the 21,000 which were projected. While this number may be disappointing, he noted that in two other states where the federal government runs the program, no one has yet enrolled. The issue is price – in the two other states, the price of the subsidized insurance was approximately the same as other insurance policies. New Jersey was able to negotiate a 30% discount in the individual health policies and the program has no pre-existing condition exclusion. Mr. Schwaneberg asked members to let their customers know about this program, as it can offer real help to certain patients.

Chairman Wise thanked Mr. Schwaneberg for sharing this information and noted the need to identify community health needs, like Alzheimer's, and any gaps in service that currently exist, or may exist in future, with regards to treating such diseases.

Members then discussed the need for primary care services and the ongoing regionalization of services across New Jersey. The need for mental health care, including services for those with alcohol and drug addictions, and adolescents with behavioral health issues, was noted. Patients with these medical issues often access care through hospital emergency rooms, since the capacity to provide this care in the community does not yet exist. There is a need for stronger community health structures, in order to provide better access to quality care. The transition to a "medical home" system of care could potentially provide the integrated care that is needed, as shown by Dr. Brenner's model. Justine Ceserano noted that the NJ Primary Care Association has a new grant which integrates behavioral health services with the primary care model at two Community Health Centers (CHCs). Members also discussed integrating behavioral health care into all models of care, and determining how and where these patients will be served.

The discussion then turned to the need to foster inter-professional education to facilitate the new team models of health care delivery. Several new medical schools now connect

medicine, nursing, public health and pharmacy studies. Linking students through inter-professional simulation activities and case studies helps to break down the “silos” of training. Education can be used to foster the team delivery of care, through models that blend team building with clinical expertise. However regulations of job responsibilities and licensing issues may limit the roles of team members in the team delivery model. The Council should explore common models of training and team delivery that can be replicated throughout the state.

Members also discussed the need to elevate the value of community health workers. The low pay and perceived low value of these paraprofessionals makes it difficult to attract and retain employees in these jobs. There is also a Medicaid reimbursement issue, which may limit the use of community health workers.

Members discussed the Medicaid reimbursement rates issue in a wider framework. Bob Schwaneberg indicated that with the anticipated high demand for primary care physicians in 2014, the federal government and the state may have to maintain a higher reimbursement rate to support the provision of these services.

Members discussed the reduction of “unnecessary readmissions” to hospital emergency rooms, since Medicaid and other insurers will no longer pay for these readmissions. The Council may wish to explore the current number of unnecessary readmissions in acute care hospitals in New Jersey, and whether reducing these readmissions will realize savings through the reduction of specialists on staff, fewer tests performed and other costs related to ER admissions. The savings realized by acute care providers might be used to move their systems of care into community health settings. Members noted that the federal act on unnecessary readmissions may have cut funding for services too deeply. It was also noted that the federal government has kept the money which has been saved, rather than reinvesting it in community health programs.

Chairman Wise introduced the issue of regionalization, noting the recent merger of Hackettstown/Hackensack medical centers. These mergers may reduce the demand for certain professional specialties. Regional data could be used to explore the true demand versus the perceived need for certain services. He then asked the Council members to discuss their thoughts on regionalization and to share any regionalization efforts happening in their areas.

Dr. Susan Walsh noted that hospitals in Newark and Trenton are sharing their professionals now, even among larger health care systems that have significant resources. Dr. Walsh encouraged the Council to explore models from other states, such as education models that are built around the new type of team care delivery, and then explore utilizing these models in our state educational institutions. With regards to behavioral health, Dr. Walsh indicated that pediatricians are interested in doing more management of behavioral health for their patients. However there are limitations surrounding the coding and billing of such services. Dr. Walsh indicated that a short- term fix would be to allow primary care physicians and pediatricians to code and bill insurers for behavioral health services.

The members discussed the limitation of hospital mergers by the Federal Trade Commission, under U.S. anti-trust laws. This is seen as a federal barrier to the regionalization of services. The Stark Law and Civil Monetary and Penalty Law were mentioned as limiting the ability of health care providers to work together and share reimbursements. Dr. Walsh noted that North Carolina had used waivers to help providers avoid conflict with the anti-trust laws.

Several Council members indicated the importance of considering the wages, training and work settings for health care professionals, and how to motivate, recruit and retain such workers. In particular, the low pay of certified nursing assistants, home health aides and community health workers was noted. In many cases these workers can earn better wages at in-patient settings rather than out-patient, so it may be a challenge to attract them to community care settings. The Council's efforts should focus not only on identifying the number of health care workers needed, but also the specific types of care centers where they will be needed, and the specific services that will need to be provided. The Council needs to explore the transitioning of workers from acute care settings to community care settings.

Members recommended that the Council explore how to maintain a high quality of care in a more dispersed system. In addition, there may be a consumer perception that care provided at home or in community settings is not as high-value as services delivered by acute care facilities. Consumers are confused by the choices of care, the different ways to access care, and the insurance reimbursement rates for care. The future health care system may need consumer advocates to guide and inform patients, when making choices about their health care needs and how to access the appropriate services.

Chairman Wise indicated the work of the Council would be to “kick start” the change process, coming up with short-term solutions to existing problems where possible, as well as projecting mid-term and long-term workforce objectives to address health care needs, recognizing that these future needs will be impacted by our aging population and the ever-changing world of health care reform.

III. Pipelines of Occupations – Robin M. Widing, Acting Executive Director, State Employment and Training Commission

The scoring of the occupational priorities in the survey reflects the current demands and challenges in the supply of health care workers. This is shown in the high ranking of home health aides. Members noted that geographic breakdowns would be helpful, particularly with regard to the “over supply” of workers in some areas that creates unemployment in occupations that are in demand in other areas of the state. The Department of Labor and Workforce Development (LWD) has several data resources, and many can be drilled down to the county level, however these need to be targeted with the right data questions. There is a lack of clarity around job titles and descriptions; for example, it is not clear in what category community health workers are counted.

Members discussed the salary disparity between public health nursing and other nurse employers. Lower salaries also deter physicians from going into primary care. Chairman Wise noted that Hunterdon currently retains half of the graduates from its residency training program. This retention rate might be further improved if relationships with other area hospitals could be used to offer a wider range of job opportunities to the graduates.

Members discussed geriatrician training programs; there are just a few graduates in this field in New Jersey each year, and the reimbursement rate here is low, which prompts these graduates to go elsewhere. Dr. Anita Franzione has statistics projecting that by 2020, there will be only one geriatrician for every 5,000 people over the age of 65 in New Jersey. Internists and family practice physicians could also provide this type of care, but it may not be enough. Geriatric advanced practice nurses would be a huge help, however they are not reimbursed at all under Medicare/Medicaid. Chairman Wise noted that Hunterdon employs its own geriatricians and maintains relationships with the area nursing homes. The model works because it avoids many unnecessary readmissions, allows doctors to treat their patients in the right setting, and enables doctors and staff at the nursing homes to promptly deal with any acute care conditions. This is a positive model for the hospital, but would need support and incentives to be replicated statewide. The model allows care to be moved into community settings, and utilizes the strength of the hospitals to ensure quality of care. Further data is needed on the number of geriatricians per patient within the various institutions. Mr. Dwyer noted that Children's Hospital employs 30 doctors – it is a successful enterprise and results in great retention rates. He noted a huge need for developmental pediatricians.

Robin Widing indicated that a future activity could be to ask Council members to identify workable models, as well as the needed data and resources to support these models.

Dr. Walsh indicated that the Commissioner of Health is supporting the creation of a web-based Center for Innovation; this could be a resource for the Council and assist with development of these models. Cathleen Bennett is Director of Policy at Health and will be replacing Dr. Walsh on this Council. Dr. Walsh requested that the Council include the associated costs of care in their examination of the new models of care. She noted that good quality care costs money, and the goals should be to bend the cost curve so that better care can be accessed by the greatest number of people.

IV. Update from HRSA Grantee Meeting – Sheryl Hutchison

Sheryl Hutchison attended the first technical assistance conference for the Health Resources and Services Administration (HRSA) grantees in Washington, DC on February 8 and 9. Ms. Hutchison reported that the conference was attended by grantees from 26 states. New Jersey is one of the 25 states that were awarded planning grants of \$150,000. One state, Virginia, was awarded an implementation grant of \$2 million. The two-day conference centered on data collection efforts. Presentations from Virginia, North Carolina and New York gave examples of the types of health workforce data collected in these states. HRSA is asking all grantees to identify the types of data

collected in their states, where this data is housed, and how is it being used. HRSA is interested in having states collect health workforce data in a structured and consistent manner, so that each state's data can support a national database of health workforce information. A new Health Workforce Information Center website, HWIC.org, features an online library of information from around the country, including resources available within each state.

HRSA is focusing on gathering workforce supply and demand data through various state agencies including licensure boards, Area Health Education Centers, the Department of Health, and the Department of Labor. This includes gathering specific demographic data on the workforce. HRSA is developing minimum data set questions for states to use to collect this demographic information. Education data is another key piece that HRSA is asking grantees to identify, including the types of programs offered in the state, the capacity of those programs, and the graduation rates and retention rates.

Virginia has done intensive geo-mapping of resources. One example illustrates how this data is helpful: Virginia determined that it had sufficient numbers of dentists for its population; however when the dentists were mapped by location of practice and whether they accepted Medicare/Medicaid, the map showed many "dental deserts" where dental services were not available. This kind of data mapping is a goal that HRSA is asking other states to work toward. North Carolina and New York have established state centers to collect and analyze health workforce data. Also, the Affordable Care Act established a new National Center for Health Workforce Analysis, led by Ed Salsberg, formerly the director of the New York Center for Health Workforce Studies.

The Council's primary work will be to use data to identify the supply, demand and education needs of New Jersey's health workforce. The long-term goal that HRSA has given each grantee is to explore the creation of a sustained structure of longitudinal health care data collection and analysis in their state, to better inform federal, state and local policy decisions.

Members indicated that support from the Governor's office would be needed to establish a state structure for sharing of data between its institutions, including Health, Human Services, Labor and Consumer Affairs. Further discussion of the Council's data needs included the vacancy rates for a wide array of health care professions and staffing ratios for various institutions and care settings. Members also discussed the difficulty of establishing common job title definitions; they suggested using clusters of job titles and focusing on the skill sets and accreditations that are needed, rather than the title itself. It was noted that the U.S. Department of Labor has a website, www.ONETonline.org which uses Standard Occupational Classification (SOC) codes for job title definitions. HRSA's Health Workforce Information Center, www.HWIC.org also provides job title definitions for health care professions.

V. Roundtable of Member Resources – Robert P. Wise

Members offered several suggestions for data resources, which can be explored by the Data Task Force:

- Salary Survey and Hospital/Employer data on the aging workforce from New Jersey Hospital Association (NJHA)
- Unemployment Claims and Wage Data from the Department of Labor and Workforce Development (LWD)
- Medicare/Medicaid data from the Department of Human Services (DHS)
- Public Health Workers data from the Department of Health (DHSS) and from DHS
- Supply-side data from DHSS
- Roster of programs offered by 19 community colleges, from Council of County Colleges (Bob Rosa can provide)
- Annual Survey and Supply/Demand Forecasting Model from the NJ Collaborating Center for Nursing, operating in conjunction with the state Board of Nursing
- NJ Center for Health Statistics at DHS
- HRSA Bureau of Health Professions
- Surveys done by the American Association of Colleges of Nursing and the National League for Nursing
- Licensure data from the health-related licensing boards overseen by the Division of Consumer Affairs, including the number of licensed workers, the number who are practicing, the number who accept Medicare/Medicaid and demographics of workers
- Data on Behavioral Health services provided by state-funded programs
- Reports on Future of Aging, Alzheimers and dementia (Dr. Franzione can provide)
- County Health Rankings from across the country, www.countyhealthrankings.org, collected by the Robert Wood Johnson Foundation (Andrea Daitz can provide) and other data that the agency collects at the federal level
- Student degree completion data from the Commission on Higher Education (Betsy Garlatti can provide)
- Provider network data, information on gaps in communities, mental health and substance abuse services, and community needs for health care workers not in acute care settings
- Turnover and vacancy rate data from VHA surveys
- Local WIB data on health care training program completers, including graduation dates and the occupations the graduates are employed in after graduation (Local WIBs or LWD can provide)
- Occupational Employment Statistics survey from LWD, which uses SOC codes and is broken down geographically and by NAICs codes (Jason Timian can provide)
- American Association of Schools of Health Professions and the Health Professions Network

- Quick Facts report from the Primary Care Association (Justine Ceserano can provide)
- Health Care Association and Nursing Home Association
- Uniform job titles from the Joint Commission
- Data from the National Association of Children’s Hospitals and Related Institutions
- Career and Technical Programs approved by the Department of Education, including the past program completers at both secondary and adult level
- Primary Care information from the Robert Graham Center in Washington, D.C.
- Health care trend data from dissertations in various fields
- Council of Teaching Hospitals report
- California Alzheimers Study, published through National Governor’s Association
- 2014 Medicaid Demographics data from Rutgers (Bob Schwaneberg will share when it is available)
- Financial data Health Care Facilities Financing Authority and from rating agencies, showing vulnerabilities of various agencies
- K-12 Education pipeline data from the Department of Education, including pass/fail rates for biology and science courses

In addition, Betsy Ryan offered to have NJHA conduct a new survey, using questions developed by the Council. Members noted that assistance from the Governor’s office would be critical in order to access data from the Division of Consumer Affairs and Medicare/Medicaid sources. Bob Schwaneberg indicated that he was not the liaison to the Division of Consumer Affairs, but offered to bring any specific requests to the attention of David Rebeck, the Governor’s policy advisor.

Lynn Mertz briefly described the work of the Future of Nursing, Regional Action Coalition, which will include a “Data Pillar” to address health care workforce data. The efforts of this group will be coordinated with the Council’s Data Task Force; Sheryl Hutchison will serve on the Data Pillar.

Members discussed the need to examine in detail the education pipelines and occupational issues. An Education Task Force will be formed to facilitate this work for the Council.

Chairman Wise noted that there may also be new professions to be identified; the emerging care navigator or care extender role may be a priority occupation. Volunteers could possibly fill this role. Medical translators may also be a new priority occupation, due to the ethnically diverse population of New Jersey. It will be important for these translators to be trained, not only to translate words, but to be able to guide and advise patients. Betsy Ryan indicated that NJHA has resources on interpreter training which NJHA actually conducts, and can share this information with the Education Task Force.

Members discussed the need for better standardization of education curricula. Chairman Wise noted that what may be needed is a “health education exchange” so that changing job practice requirements can quickly and easily be communicated from employers to

education institutions, to facilitate the ongoing matching of curricula with the current needs of the workplace.

Council members were identified to serve on the Data Task Force and the Education Task Force.

VI. Conclusion and Next Meeting

Chairman Robert Wise thanked the members and concluded the meeting at 10:30 am.

The next Council meeting will be held **Friday, April 15, 2011 at the Hunterdon Medical Center in Flemington, starting at 8:30 am.**

Member Attendees – February 18, 2011

Bakewell-Sachs, Susan, NJ Nursing Initiative
Barnard, Susan, Bergen Community College (for Mr. Ryan)
Brady, Jane, Middlesex Workforce Investment Board
Ceserano, Justine, NJ Primary Care Association (for Ms. Grant-Davis)
Daitz, Andrea, Robert Wood Johnson Foundation (for Dr. Ladden)
Dwyer, William, PSE&G Children's Specialized Hospital
Egreczky, Dana, NJ Chamber of Commerce Foundation
Franziona, Anita, Parker Memorial Home Inc., Nursing Care Residence
Garlatti, Betsy, State of NJ Commission on Higher Education
Harz, John, Visiting Nurse Association of Central Jersey [phone]
Krepcio, Kathy, Heldrich Center for Workforce Development
Moran, Janet, Lourdes Health System
Orchard, Patricia, Horizon Blue Cross Blue Shield of New Jersey
Rosa, Robert, NJ Council of County Colleges (for Dr. Nespoli)
Ryan, Betsy, NJ Hospital Association
Salmond, Susan, UMDNJ School of Nursing
Savage, Judy, NJ Council of County Vocational-Technical Schools
Sperling, Deanna, Organization of Nurse Executives, ONE/NJ
Treacy, Virginia, District Council 1, IUOE/AFL-CIO
Walsh, Susan, NJ Department of Health and Senior Services (for Commissioner Alaigh)
Weaver, Kathy, Newark Alliance
Wise, Robert, Hunterdon Healthcare
Zastocki, Deborah, Chilton Memorial Hospital

Guest/Staff Attendees – February 18, 2011

Cooper, Belinda, NJ Hospital Association
Hutchison, Sheryl, NJ State Employment and Training Commission
Kocsis, Violet, Hunterdon Healthcare
Mertz, Lynn, NJ Nursing Initiative
Schwaneberg, Robert, Policy Advisor to the Governor for Health Care
Shlimbaum, Terry, Hunterdon Healthcare
Timian, Jason, NJ Department of Labor and Workforce Development
Widing, Robin, NJ State Employment and Training Commission